STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 01 B. WING	07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF FT WAYNE	6006 BRANDY CHASE COVE FORT WAYNE, IN46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/12/11 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Regency Place of Fort Wayne was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 160 and had a census of 147 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/18/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0038 SS=C	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 123 of 147 residents without a clinical diagnosis requiring specialized security measures were allowed access to 10 of 11 locked exit doors. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K0038	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. K038 1. Signage was posted on 07.29.11, providing awareness to residents directly mentioned	08/13/2011

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	Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect one hundred and twenty three residents. Findings include: Based on observations with the Maintenance Director on 07/12/11 during a tour of the facility exit doors from 11:35 p.m. to 3:00 p.m., all eleven exit doors were held in the locked position with a magnetic hold down device. Furthermore, all exit doors were equipped with an electronic keypad entry system allowing staff to open the locked exit doors with a combination. Based on an interview with the Maintenance Director by phone on 07/14/11, the only residents with a diagnosed clinical behavior were the residents located in the		in the citation as potentially affected. The signage indentifying exit doors as a means of egress was added to the front door which has a 15 second delayed egress function. 2. No other residents were potentially affected by cited practice, as all residents were included in survey. Door Security System Standards reviewed to ensure none of residents potentially affected had a negative outcome as a result – none were noted. 3. Door Security System Standards reviewed. All staff will receive education related to compliance with the Door Security Standards. 4. A performance improvement tool has been developed to ensure ongoing compliance. the maintenance director or designee will utilize to monitor daily that signs are in place for identification of delayed egress. The tool will be completed daily for 30 days and reviewed at the monthly Performance improvement Meeting for compliance.	

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	Reflections hall and according to facilities policy the code is not posted anywhere in the building. Residents must ask a staff member in order to exit the building. 3.1-19(b)			
K0051 SS=E	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 1 manual fire alarm boxes at the main entrance was readily accessible. NFPA 72, National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes	K0051	K0511. The survey identifies no specific resident, only that "deficient practice affects any residents at the main entrance area. No residents incurred negative outcomes as a result of this	08/13/2011

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	shall be distributed throughout the protected area so they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice affects any residents at the main entrance area. Findings include: Based on observations with the Maintenance Director on 07/12/11 at 2:50 p.m., the manual fire alarm pull station at the main entrance was not readily accessible in that the pull station was located beyond the magnetically locked exit doors and would require the use of a code to access the pull station. The code was not posted. Based on interview at the time of observation, the Maintenance Director acknowledged a staff person would have to enter the code in order to open the door and access the pull station. 3.1-19(b)		practice. 2. To ensure compliance and safety for all residents, A fire pull station will be added to the front lobby area (identified as “main entrance area”) on the egress side. This will ensure that the manual fire alarm box is unobstructed, readily accessible, and located in the path of exit from the area. koorsen’s fire protection will install new pull station, and will be completed by 8/5/2011 3. All staff will receive education related to compliance with the Door Security Standards. All staff will receive education related to the relocation of the pull station and proper utilization. 4. the pull station will be added to koorsen's fire protection’s inspection report and to regency’s preventive maintenance program and monitored by the maintenance director, or designee. The fire	

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			protection inspection report as well as the preventative maintenance log will be reviewed at the Monthly Performance Improvement Meeting by the Performance Improvement Team.	
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
	Based on observation and interview, the facility failed to ensure the spray pattern for an all of sprinkler heads were unobstructed in the attic area adjacent to the mezzanine. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient	K0062	K062 The survey identifies no specific resident, only that it could affect “any number of staff”. No residents or staff incurred negative outcomes as a result of this practice. The facility has contracted Viking Fire Protection to add 13 sprinkler heads to the attic area in question above the kitchen. This will ensure , in accordance with nfpa #13 (1999 edition), compliance with state and local requirements. the 13	08/13/2011

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	practice was not in a resident care area but could affect any number of staff. Findings include: Based on observations with the Maintenance Director on 07/12/11 at 1:50 p.m., the spray pattern of all of the sprinkler heads in the attic adjacent to the mezzanine was obstructed by fiberglass insulation supported by wire mesh which was installed below the sprinkler heads. Based on an interview with the Maintenance Director at the time of observation, the attic sprinkler heads were above the insulation. 3.1-19(b)		heads will be installed by viking fire protection, and completed by 8/12/2011 The corrective measures outlined in step (1) above will provide compliance with nfpa #13 (1999 edition), with state and local requirements for all residents. The staff responsible for required inspection, preventative maintenance, and overall compliance will receive education related to additional 13 sprinkler heads. 4. the sprinkler heads will be added to the quarterly sprinkler inspection monitored by koorsen fire protection. The maintenance director or designee will monitor inspections. the preventative maintenance log will be reviewed at the Monthly Performance Improvement Meeting by the Performance	

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			Improvement Team for ongoing compliance.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the	K0144	K144 The employee that completed the "Emergency Generator Monthly Log Sheet", identified as deficient, was provided education related to NFPA and Life Safety Codes cited in K144. Following the survey findings, an emergency Generator exercise was completed and transfer times were recorded in compliance with NFPA 99 3-5.4.2 to ensure safety through compliance for all "all occupants" All staff responsible for documentation related to generator engine exercises under operating conditions, as required by NFPA, were	08/13/2011

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	authority having jurisdiction. This deficient practice affects all occupants. Findings include: Based on review of the generator log titled "Emergency Generator Monthly Log Sheet" with the Maintenance Director on 07/12/11 at 11:35 a.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not include the time for the transfer of power from the main source to the generator. This was acknowledged by the Maintenance Director. 3.1-19(b)		educated immediately following the deficient practice. Documentation of the transfer times will be completed and monitored using the emergency generator Monthly/ and Weekly Log Sheets. Ongoing compliance will be monitored by review of the “Emergency Generator Monthly Log Sheet” and the “Emergency Generator Weekly Engine Exercise Sheet”. A Performance Improvement Tool was developed to monitor the review of compliant documentation during testing. The Performance Improvement Team will review all documentation of exercises at the monthly Performance Improvement Meeting.	